REMARKS

In the above Office Action the Examiner has rejected Claims 1, 13, 15, 17, 19 and 21 as unpatentable over Cipla. It is assumed that the Examiner deduced the 2000 publication date from the copyright notice at the end of the page. Applicant has accessed the same website and obtained Exhibit 1 showing on its face a publication date of 2008, yet having the same copyright notice date of 2000. Therefore Applicant concludes that the copyright notice date does not refer to the year of publication of that particular page, and thus there is no indication of when the Cipla reference was published. Without any indication, the reference cannot be used.

Further, the Examiner has admitted that the Cipla reference does not expressly teach the dosages set forth in Claim 1. Applicant notes that with its formulation it is able to obtain fewer adverse affects with a lower dosage, and is able to achieve these less adverse affects while maintaining the same effectiveness. The lower dosage is critical in achieving this accomplishment. The lower dosage of these ingredients is not taught or suggested in the art of record. Thus, it is believed that Claims 1, 13, 15, 17,19 and 21 are patentable over Cipla.

Claims 2, 3, 5, 18, 20 and 22 have been rejected as unpatentable over Cipla in view of Gillis et al. Applicant disagrees with the Examiner's application of Gillis and Cipla. First, Cipla teaches the combination of one tablet of Fluconazole (150mg) and two Tinidazole tablets, totaling 2000 mgs. There is no suggestion in Cipla that Applicant's regime of less than 150mg Fluconazoleand less than 2000mg Secnidazole would be effective. Thus there is no motivation for one to be adding a third ingredient to Cipla. Applicant has amended Claim 2 so the claim now recites that the formulation "consists essentially of" only the Fluconazole and the Secnidazole and excludes the third ingredient of Tinidazole, which one would necessarily include in the formulation were one to combine Cipla and Gillis. As a result Applicant believe, as amended, Claims 2, 3, 5, 18, 20 and 22 now define over the combination of Cipla and Gillis.

Further, the rationale for adding the two ingredients (Fluconazole and Secnidazole) is that one might decrease the dosage of both ingredients to thereby avoid the side effects of each by itself in the increased dosage. This approach is not suggested in either Gillis or Cipla and accordingly, Applicant believes its formulation to be patentable thereover.

Claim 6 has been rejected as unpatentable over Cipla and Gillis further in view of U.S. patent 5,660,860. Applicant believes that in so far as Claim 6 is dependent upon Claim 2 and incorporates all of the limitations thereof, that Claim 2 is patentable as set forth above, and therefore Claim 6 also remains patentable.

Applicant hereby requests reconsideration and reexamination thereof.

With the above amendments and remarks, this application is considered ready for allowance and applicant earnestly solicits an early notice of same. Should the Examiner be of the opinion that a telephone conference would expedite prosecution of the subject application, she is respectfully requested to call the undersigned at the below listed number.

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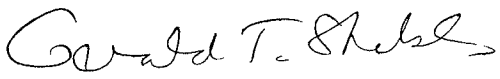
Respectfully submitted,



Dated: October 23, 2008

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Exhibit 1

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News Update

Page updated on 07th October 2008

Moxifloxacin, a Powerful Antimicrobial with Rapid Response Rates in Leprosy

Moxifloxacin is a "powerful" antimicrobial in the treatment of leprosy, reported researchers at the Leonard Wood Memorial Center for Leprosy Research in Cebu , Philippines .

The clinical response is incrediblyrapid and evidence has been after a single dose. After eight days, there is a significant microbial response. With standard therapy, it may take months before response can be seen, said Dr. Gelber.

In the current study, eight multibacillary leprosy patients were given a single 400 mg dose of the fluoroquinolone. Microbial killing rates ranged from 82% to 99%, with a mean response of 91%.

In all instances, no viable bacilli were detected with an additional three weeks of daily therapy, this observed rapid bactericidal activity being matched previously only by rifampin, wrote the researchers.

Skin lesions cleared exceedingly rapidly, with mild adverse effects, which all resolved after the treatment course had ended, said the investigators.

Since relapses can occur very late in leprosy, and can take place up to as long as a decade later, no definitive conclusions can be drawn at this point, Dr. Gelber noted.

No one would actually treat leprosy with monotherapy, said Dr. Gelber. He would want to be treated with moxifloxacin and rifampin as first line therapy, he added.

Source : *Antimicrob Agents Chemother*2008; 52:3113-3117.

Top

CD4 Monitoring of HIV Patients a Cost-Saving Strategy in Poor Countries

Relying on CD4 counts rather than patients' symptoms to determine when to initiate antiretroviral therapy is a cost-effective approach for managing HIV in resource-limited settings, according to a study conducted in South Africa .

Using data derived from HIV cohorts in the Cape Town area, the research team developed a simulation model of the history of HIV-positive patients from time of presentation for care until death. They then compared the costs and benefits of management strategies based on patient symptoms, in which HAART would be initiated after a first severe opportunistic disease; routine measurement of CD4 counts; or combined measurements of CD4 counts plus viral load.

CD4 count monitoring could substantially increase life expectancy and reduce total costs relative to the symptom-based approaches currently practiced in many regions, especially outside of major urban areas, reported the investigators.

In particular, monitoring CD4 counts every 6 months and starting HAART at a threshold of 350 cells/L would increase life expectancy by approximately 12 months, at a discounted lifetime cost saving of about $400. In this scenario, the costs of testing and treatment are outweighed by reduced rates of hospitalization.

The addition of routine viral load assessment would further increase life expectancy by about 2 months, but at substantially increased cost, the authors noted.

Dr. Owens and his associates acknowledged the expensive investment required to offer CD4 monitoring, but these challenges are increasingly surmountable, they added. Recent advances in CD4 enumeration technology enable lower per-test cost, as well as smaller machines that require relatively little infrastructure, maintenance, and technical expertise.

Source: *Arch Intern Med* 2008;168:1910-1918.

Top

Early and Late-Stage HIV Infection More Infectious Than Believed

The early (primary) and late stages of HIV-1 infection appear to be more infectious than previously estimated, but for shorter periods of time, reported researchers.

First author Dr. T. Deirdre Hollingsworth from Imperial College London, UK, said: "It is important to quantify the proportion of transmissions due to each stage of infection. This is highly dependent on the relative infectiousness of each stage and how long they last."

To obtain better estimates of the contribution of different stages to transmission, Dr. Hollingsworth and colleagues re-estimated the risk of transmission and the duration of high HIV-1 transmissibility during primary, asymptomatic, and late-stage infection from a study of initially HIV-1-serodiscordant heterosexual couples in Uganda.

Based on a "robust probabilistic framework", researchers estimated that primary infection and late-stage infection were 26 and 7 times, respectively, more infectious than asymptomatic infection.

They further estimated that high infectiousness during primary infection is likely to last for approximately 3 months after seroconversion, whereas infectiousness during late-stage infection seems to be highest between 19 months and 10 months before death.

The period of high infectivity during primary infection coincides with the 2 to 3 month period of high viral loads observed in patients, the investigators noted.

Recent years have seen increasing incidence of HIV in some North American and European cities, said Dr. Hollingsworth. In such resurgent epidemics amongst high-risk groups, early infection testing has the potential to slow the spread of HIV, but only if new infections can be rapidly identified and contact tracing is highly effective.

As an epidemic develops and more infected individuals progress into the less infectious asymptomatic stage, they will continue to cause onward infections and the role of early infection will diminish, Dr. Hollingsworth noted. "This is more likely to be the case in the mature epidemics in sub-Saharan Africa . In these areas, diagnosis at the late stages should be the first public health priority, followed by more costly early infection testing once widespread testing is more frequently accessed," she concluded.

Source: *J Infect Dis* 2008; 198:687-693.

Top

Canadian Diabetes Association Launches New Clinical Practice Guidelines

The Canadian Diabetes Association has released new clinical practice guidelines to emphasise the importance of early identification of risk factors in the prediabetes stage in order to prevent the

onset of diabetes and the aggressive management of those risk factors in order to prevent the serious complications associated with the disease.

The Guidelines provide clinicians with detailed information about how to best manage diabetes, with a large focus on the prevention and management of the serious complications associated with diabetes, particularly heart disease," said Gillian Booth, MD, Department of Medicine, University of Toronto, and Expert Committee for the 2008 Clinical Practice Guidelines, Toronto, Ontario.

The Expert Panel committee responsible for the development of the Guidelines includes 99 volunteers representing a broad variety of healthcare professionals from across the country. A number of new chapters have also been added to the Guidelines, widening the scope to address emerging research in diabetes-related care.

The Guidelines recommend a multifaceted, comprehensive approach to diabetes management, which includes healthy meal planning, physical activity, smoking cessation and tight control of important targets, such as blood pressure, cholesterol, and blood glucose levels.

Furthermore, the Guidelines now provide clinicians with more information on how to best screen people with diabetes for cardiovascular risk. Research has proven that the risk of heart disease can be reduced by more than 50% through a combination of lifestyle approaches and medications that protect against cardiovascular disease.

The Guidelines define prediabetes as a fasting plasma glucose (FPG) level of 6.1 to 6.9 mmol/L or presence of impaired glucose tolerance on a 75-gram oral glucose tolerance test (OGTT). For those individuals with an FPG level between 5.6 and 6.0 mmol/L and one or more risk factors for diabetes, the Guidelines recommend performing an OGTT.

Development of type 2 diabetes in patients with prediabetes can be delayed or prevented with lifestyle changes and if required, medication.

Select Recommendations
- Early identification and treatment of risk factors for diabetes-related complications such as cardiovascular disease, kidney, and eye disease is essential through proper disease management to avoid serious complications.
- The Guidelines are now recommending that people with diabetes who are at risk for developing heart disease be aggressively treated to lower low-density lipoprotein (LDL) cholesterol to <=2 mmol/L. This lower level, in combination with strict blood pressure control, is proven to help substantially reduce heart disease and stroke.
- People with diabetes are encouraged to perform resistance exercises in addition to moderate to vigorous aerobic exercises, such as brisk walking.
- Adults with diabetes should consume no more than 7% of total daily energy from saturated fat and should limit intake of trans fatty acids to a minimum.

Source: *Canadian Journal of Diabetes*. September 2008

Top

Thrombolysis Appears to Be Safe Up to 4.5 Hours after Stroke Onset

Observational data from a large European registry suggest that thrombolysis may be safe up to 4.5 hours after stroke onset, an hour and a half longer than current recommendations of a 3-hour limit. These results are published in the September 15 Online First issue of Lancet .

In this study, the authors used data from the SITS, a prospective, Internet-based audit of the ISTR. SITS represents the collaboration of more than 700 clinical centers in 35 countries documenting the use of tPA, where all treated patients are registered whether they meet approved criteria for treatment.

In this analysis, they compared outcomes in 664 patients who were given tPA between 3 and 4.5 hours after symptom onset vs. those of 11,865 patients treated within the recommended 3-hour window. Except for the time window in which they were treated, all patients still met the criteria for treatment, including a computed tomography scan clear of any evidence of bleeding. The decision to treat with tPA after 3 hours was made in the institutions and would have been made on an individual basis.

In the 3- to 4.5-hour cohort, treatment was started at a median of 55 minutes later after symptom onset, at approximately 195 minutes vs. 140 minutes in the 3-hour cohort ($P < .001$). These patients were also significantly younger and had less severe strokes than those treated within 3 hours.

In the end, the investigators found no significant differences between patients treated within 3 hours and those treated between 3 and 4.5 hours in the rate of symptomatic intracerebral hemorrhage, mortality rate, or the rate of those who were independent (modified Rankin scale 0 - 2) at 3 months.

"Alteplase remains safe when given at 3 - 4.5 hours after ischemic stroke, offering an opportunity for patients who cannot be treated within the standard 3 hour timeframe," the study authors conclude.

In a commentary accompanying the publication, Georgios Tsivgoulis, Democretus University of Thrace, University Hospital Alexandroupolis, Greece , and André V. Alexandrov, University of Alabama, Birmingham, call the results, "promising nonrandomized data which show that extension of the time frame of thrombolysis might be a safe and feasible option."

They note that after adjustment for potential confounders, there was a nonsignificant increase in the risk for symptomatic intracerebral hemorrhage and mortality in this study, amounting to absolute differences of 0.6% and 0.5% respectively, although imbalances in baseline characteristics may have accounted for this.

In addition, half of the patients in the 3- to 4.5-hour cohort were treated just 15 minutes after the 3-hour limit, they point out, with 60% treated within 180 to 200 minutes after symptom onset. Although understandable, "this skew could weaken the overall impression that reliable data are available for 3 - 4.5 hours," they note.

Drs. Tsivgoulis and Alexandrov also add that symptomatic intracerebral hemorrhage was self-reported by the investigators, which means potential selection bias cannot be ruled out, and because patients older than 80 years and those with more severe strokes (NIHSS score > 25) were excluded, these results cannot be generalized to these patients.

"Whether ECASS 3 is positive or not, the SITS-ISTR findings support continuing efforts to extend the time frame for thrombolysis," Dr. Tsivgoulis and Alexandrov write. Another trial in this extended period, the International Stroke Trial 3 is also ongoing, and other trials selecting patients for treatment on the basis of imaging studies are also underway.

"We are looking forward to moving away from rigid timeframes to treatment on the basis of imaging that can assess brain pathophysiology and tissue viability," they conclude.

Source: *Lancet* Published online September 15, 2008

Top

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